



MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246

Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us

MN Relay Service for Hearing Impaired (800) 627-3529

Athletic Trainer Advisory Council 2015 Meeting Dates and Deadlines

Upon receipt of your application and documentation, you will be put on the next Council and Board agendas unless you specify a particular Board. It is your responsibility to make sure your file is complete; i.e. verifications, completed application, and documentation have been received by the Board. As a general rule, the application and documentation must be received two weeks prior to the next Council meeting as indicated below.

AT Document Deadline

December 3, 2014
February 4, 2015
April 1, 2015
June 3, 2015
August 5, 2015
October 7, 2015
December 2, 2015

Council Meeting

December 17, 2014
February 18, 2015
April 15, 2015
June 17, 2015
August 19, 2015
October 21, 2015
December 16, 2015

Board Meeting

January 10, 2015
March 14, 2015
May 9, 2015
July 11, 2015
September 12, 2015
November 14, 2015
January 9, 2016

2016 Dates to be Determined

**All Athletic Trainer Licenses
Expire June 30th of Each Year**



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ATHLETIC TRAINER FACT SHEET

History

The Minnesota Legislature enacted a law in 1993 establishing a registration system for athletic trainers. The Board of Medical Practice enforces the requirements of the athletic trainer registration system and provides information to consumers and other interested persons.

Athletic Trainers Advisory Council

The Athletic Trainers Advisory Council was appointed by the Board of Medical Practice to advise the Board on issues regarding athletic trainer registration standards, enforcement of rules, and complaint review. The Council is composed of three athletic trainers (one who is also a physical therapist), two physicians with expertise in athletic training and sports medicine, one chiropractor with experience in athletic training and sports injuries, and two public members.

Title Protection

Nonregistered individuals are prohibited from using the words or letters registered athletic trainer, licensed athletic trainer, Minnesota registered athletic trainer, athletic trainer, A.T.R., or any other words, letters, abbreviations, or insignia indicating or implying that the individual is an athletic trainer. A student must be identified as a "student athletic trainer." The law defines a student athletic trainer is "A student attending a college or university athletic training program." Nonregistered individuals holding themselves out as an athletic trainer are guilty of a misdemeanor. Athletic trainers certified by the Board of Certification (BOC) formerly National Athletic Trainers' Association Board of Certification (NATABOC) who come to Minnesota for a specific event are exempt from the Minnesota Athletic Trainer's Act.

Registration Requirements

To establish eligibility for general registration, an applicant must successfully complete an athletic training program accredited by National Athletic Trainers' Association Professional Education Committee, the Joint Review Committee on Education Programs in Athletic Training, or the current accrediting agency and successfully complete the Board of Certification exam within one year of application for registration. General registration is appropriate for new graduates.

The exceptions to the general registration requirements and their accompanying requirements are as follows:

- A. **Registration by Equivalency.** Applicant must have successfully completed an accredited athletic training program and have a current BOC certificate. Applicants certified prior to 1971 are exempt from the accredited program requirement. Equivalency registration is suitable for individuals who have been working for a number of years in Minnesota.
- B. **Registration by Reciprocity.** Applicant must have current and unrestricted license from another state requiring an accredited program and BOC certificate. Reciprocity registration is appropriate for individuals coming from another state.

Limited Registrations

Temporary Registration. Temporary registration is available to general registration and reciprocity applicants. The BOC must be successfully completed within one year after temporary registration is issued. Athletic trainers with temporary registration are limited to working under the direct supervision of a registered athletic trainer. A registered athletic trainer may supervise no more than four athletic trainers with temporary registration status.

Temporary Permit. A temporary permit is available to applicants who meet all registration requirements and wish to practice before final approval is granted by the Board. The temporary permit is valid from the date of approval until the next Board meeting at which a decision is made on the application.

Scope of Practice

The athletic trainers evaluate and treat athletic injuries according to protocols established by the primary physician. The protocol must be updated annually at renewal time. The athletic trainer must refer patients with a medical condition beyond the athletic trainer's scope of practice to an appropriate caregiver per protocol established by the supervising physician.

Continuing Education

Each registered athletic trainer must complete at least 60 contact hours of Board-approved continuing education every three years as a condition of registration renewal. Newly registered athletic trainers commence their three year cycle on July 1 immediately following the date registration was granted. Registrants are asked to attest to completion of continuing education by reporting to the Board at renewal time. Continuing education documentation must be retained by each registrant in the event they are selected for an audit.

Renewal Cycle

Registration must be renewed annually on or before July 1 of each year. Renewal notices are sent approximately 45 days prior to expiration. It is the athletic trainer's responsibility to keep the Board advised of their current address. The Board is obligated to mail the renewal application to the address on file. Failure to receive the renewal documents does not relieve athletic trainers of their renewal obligation.

Individuals whose registered status has lapsed must submit the following in order to regain registered status:

1. documentation from a physician verifying employment in athletic training for eight weeks every three years during the lapse in registration;
2. evidence of continuing education compliance ; and
3. pay all back fees in order to regain registered status.

If any part of this Fact Sheet conflicts with the Minnesota rules or laws, the rules or laws take precedence. It is your responsibility to understand and comply with the regulations. Please call the Board offices if you have any questions.



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IMPORTANT

Expiration of E-Licensing Surcharge

In 2009, the legislature enacted MN Statute 16E.22, requiring state agencies to collect a temporary 10% surcharge of no less than \$5.00 and no more than \$150.00 for the initial application for licensure and renewal of licenses for business, commercial, professional, and occupational licenses. The surcharge fees must be collected from July 2009 through June 2015 to fund a statewide electronic licensing system.

Effective June 30, 2015, the 10% e-Licensing surcharge enacted by the Minnesota Legislature in 2009 will expire. Individuals whose application or renewal is *PROCESSED* as of 12:01 a.m. Central Standard Time on July 1, 2015, will not be assessed a surcharge. If the surcharge amount is submitted, individuals will receive a refund check for the surcharge amount from the Minnesota Department of Revenue. Submission of a surcharge fee after June 30, 2015, will not delay processing of an application or renewal.

Effective July 1, 2015

The following fees will be in effect for the initial application or annual renewal

Applicants for initial license

Fee includes the initial application fee and annual renewal fee. Does not include the temporary permit fee.

Applicants for license renewal

Fee includes the annual renewal fee. Does not include late fees.

<u>Profession</u>	<u>Initial Application Fee</u>		<u>Annual License Renewal Fee</u>	
	<u>Through 6-30-2015</u>	<u>After 7-1-2015</u>	<u>Through 6-30-2015</u>	<u>After 7-1-2015</u>
Acupuncture	\$330	\$300	\$165	\$150
Athletic Trainer	\$165	\$150	\$110	\$100
Naturopathic Doctor	\$385	\$350	\$165	\$150
Physician	\$431.20	\$392	\$211.20	\$192
Physician Assistant				
With prescribing	\$280.50	\$255	\$148.50	\$135
Without prescribing	\$258.50	\$235	\$126.50	\$115
Respiratory Therapist	\$209	\$190	\$99	\$90
Telemedicine	\$192.50	\$175	\$82.50	\$75
Traditional Midwife	\$220	\$200	\$110	\$100



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ATHLETIC TRAINER Instructions

Enclosed is your application for registration as an Athletic Trainer. Please thoroughly review these materials before submitting your application. The Board of Medical Practice is charged with administering the Athletic Trainer legislation which became effective on May 18, 1993.

Methods of Registration

The law establishes eligibility for registration through several different avenues. Applicants who are new graduates should apply under general registration. Equivalency registration is for athletic trainers who have been practicing in Minnesota for a number of years and have a Board of Certification (BOC) certificate. BOC was formerly NATABOC (National Athletic Trainers' Association Board of Certification). Applicants licensed in another state should apply under reciprocity registration. Programs accredited by the Commission of Accreditation of Athletic Training Education (CAATE), Commission on Accreditation of Allied Health Education Programs (CAAHEP), or National Athletic Trainers' Association Professional Education Committee (NATA PEC). All applicants must submit a completed application and appropriate fee.

A. General Registration Requirements

- Certification of successful completion of and approved education program; AND
- Certification of successful completion of the BOC exam within one year of application for registration.

B. Registration by Equivalency Requirements

- Certification of valid and current BOC certificate

C. Registration by Reciprocity Requirements

- Certification of current and unrestricted license from another state requiring and approved education program and BOC certificate; AND
- Certification of valid and current BOC certificate

In addition to the documentation requirements set forth under registration requirements A-C, all of the following requirements must be met or the entire application will be returned:

- Non-refundable application fee of \$55 and an annual registration fee of \$110 to be prorated at first renewal. Make checks payable to the **Minnesota Board of Medical Practice**.
- All your time must be accounted for on the application, from high school to the date of application. During continuous years of education, period of three months or less (summer break) need not be accounted for.
- The name on the application and athletic trainer diploma must be the same. If there has been a name change, submit a *notarized* copy of the documentation, e.g. marriage certificate.
- A full face, recent, 2x3" photograph must be affixed as indicated on the application and *notarized* as a true likeness.
- *Notarized* copy of athletic trainer diploma and BOC certificate, if applicable.

The following requirements must be sent directly to the Minnesota Board from the facility/person completing the form:

- All certification forms. These forms must be submitted before your application is complete. It is your responsibility to make sure these forms are completed and received by our office. The Board must receive separate certification forms completed by athletic trainer schools attended (if applying under general registration) and each state board where you have ever held a license/registration.
- BOC offers a credential verification service on their website www.bocatc.org. Click on "Certification Verification" and follow on instructions for the *Official Written Verification* or *Official Electronic Verification*. The Board accepts either one. If the *Official Electronic Verification* is requested, the email should be sent to medical.board@state.mn.us. Board of Certification, Inc. is located at 1415 Harney Street, Suite 200,

Omaha, NE 68102.

- **Recommendations** from two persons with whom you have worked during the last five years. At least one must be a physician or chiropractor. The other may be a certified athletic trainer.

The Protocol must be completed and kept in your file:

Have your primary physician complete the Protocol Form establishing evaluation and treatment protocols and maintain in your file to be updated annually at your renewal time.

Permanent Registration Process

Applicants are granted permanent registration by the Board of Medical Practice six times per year at Board meetings. In order to be granted permanent registration by the Board, the Athletic Trainers Advisory Council must first approve your application and recommend approval to the Board. Council meetings are held 3-4 weeks before Board meetings. For an application to be reviewed by the Council, the applicant must meet all application filing deadlines associated with that particular Council meeting date. *These deadline dates are included with your application.* Board meetings are held during every odd-numbered month generally on the second Saturday.

Limited Registrations

A temporary permit may be requested by an applicant who meets all the requirements for registration and who wishes to practice before final approval is granted by the Board. In order for a temporary permit to be granted, the file for permanent registration must be complete, and a completed temporary permit application form and \$50 fee must be received by the Board. The temporary permit is valid from the date of approval until the next Board meeting at which a decision is made on the application.

Temporary registration is designed for applicants who have recently graduated from an athletic trainer program, but have not yet taken and passed the BOC examination. This registration allows applicants to practice as an athletic trainer for a period of up to one year, during which time the athletic trainer must take and pass the BOC examination. For those awaiting examinations results, temporary registration expires upon receipt of examination results. Eligibility requirements for temporary registration are identical to those for permanent registration with the exception of submitting BOC examination verification. Temporary registration can be granted once the file for permanent registration is complete, and the temporary registration application form and \$100 fee have been received.

Application Fees

Please be aware that all fees are non-refundable. Fees submitted will not be refunded if it is determined that you are not eligible for registration.

Permanent Registration Application Fee: \$165 (\$55 application + \$110 annual)

This fee must be sent with a completed Application for Registration form. Applicants who apply for a temporary permit or temporary registration must also submit an application for permanent registration.

Temporary Permit Fee: \$50

This fee must be sent with a completed Temporary Permit application form.

Temporary Registration Fee: \$100

This fee must be sent with a completed Temporary Registration application form.

Annual Registration Fee: \$110

To be paid by all registered athletic trainers annually. The first renewal fee will be pro-rated.

How to Apply

If you qualify for registration and would like an application or if you have specific questions about the application process and would like to talk to someone, please call the Board at 612-617-2130. Address all written correspondence to:

MN Board of Medical Practice – AT Registration
University Park Plaza
2829 University Ave SE – Suite 500
Minneapolis, MN 55414-3246

Applicants are required to submit written notification to the Board within 30 days of any name or address change. The law takes precedence over any conflicts between these instructions and the law.

APPLICATION FOR ATHLETIC TRAINER REGISTRATION



MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us

Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

FOR BOARD USE ONLY

APPLICATION #: _____

CHECK/RECEIPT #: _____

AMT PAID: _____

TEMP REGIS #: _____

TEMP PERMIT #: _____

BOARD ACTION: _____

BOARD DATE: _____

REGISTRATION #: _____

DATE OF APPLICATION:

MONTH	DAY	YEAR

INSTRUCTIONS TO APPLICANT

1. Enter all dates as Month/Day/Year.
2. Please type or print and answer all questions completely and accurately. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently registered by the Board.
3. Have attached forms completed and submitted to our office, where applicable.
4. Read the attached rules regarding Athletic Training Registration.
5. Contact the Board office regarding the next Council meeting date to determine the deadline for submitting your application. The Athletic Trainer Council meets every other month.
6. See the attached Registration Instructions for information regarding fees to be submitted with your application.
7. The name you enter must exactly match the name on your Athletic Trainer certificate or documentation of formal name change must be submitted.
8. The application fee is not refundable.
9. Incomplete applications will be destroyed after six months inactivity.

ACCOUNTCODE	AMOUNT
635029 reg.	
635030 app	
635031 tp	
635055 tr	
513122 sur	

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME:	LAST	FIRST	MIDDLE
STREET ADDRESS:			
CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:
HOME PHONE:	OTHER PHONE:	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	OTHER NAMES:
SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:			

RECORD OF BIRTH

BIRTHDATE (Mo/Day/Year) / /	CITY OF BIRTH:	STATE OF BIRTH:	COUNTRY OF BIRTH:
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BOC CERTIFICATION (*)

DATE OF CERTIFICATION (Mo/Day/Year) / /	CERTIFICATION NUMBER:	EXPIRATION DATE (Mo/Day/Year) / /
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(*) Attach Notarized Copy of the Board of Certification (BOC) formerly National Athletic Trainers' Association Board of Certification (NATABOC) certificate

BASIS FOR APPLICATION (CHECK ONE)

☐ GENERAL REGISTRATION ☐ EQUIVALENCY ☐ RECIPROCITY

PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL:	CITY:	STATE OR PROVINCE:	ZIP CODE:	FROM DATE:	TO DATE:
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	ZIP CODE:	FROM DATE:	TO DATE:
TYPE OF DEGREE	NAME OF ISSUING SCHOOL:	CITY:	STATE OR PROVINCE:	DATE DEGREE RECEIVED:	

ATHLETIC TRAINING EDUCATION						
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE Month/Day/Year	TO DATE Month/Day/Year	DEGREE/ CERTIFICATE
						<input type="checkbox"/> Internship program <input type="checkbox"/> Accredited curriculum program
						<input type="checkbox"/> Internship program <input type="checkbox"/> Accredited curriculum program

OTHER EDUCATION AND TRAINING						
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE Month/Day/Year	TO DATE Month/Day/Year	DEGREE/ CERTIFICATE

STATE/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED OR REGISTERED AS AN ATHLETIC TRAINER			
STATE/PROVINCE/COUNTRY	LICENSE NUMBER OR REGISTRATION NUMBER	DATE ISSUED Month/Day/Year	HOW OBTAINED?*

DRIVERS LICENSE	
STATE:	LICENSE NUMBER:

*BOC exam
Equivalency
Reciprocity

ACTIVITIES

LIST BELOW, IN CHRONOLOGICAL ORDER, ALL ACTIVITIES INCLUDING POST-GRADUATE TRAINING, HOSPITAL OR CLINIC AFFILIATIONS, AND PERIODS OF UNEMPLOYMENT. ACCOUNT FOR ALL TIME SINCE GRADUATION FROM HIGH SCHOOL.

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION		
NAME OF INSTITUTION:				
STREET ADDRESS:		CITY:	STATE:	ZIP CODE:

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information.

Y	<p>1. Is your cognitive, communicative, or physical ability to engage in the duties and responsibilities of an athletic trainer with reasonable skill and safety been impaired or limited in any way? Please describe.</p> <p>Y N 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.</p> <p>Y N 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.</p>
Y	<p>2. Does your use of alcohol or chemical substances(s), including prescription medications, in any way impair or limit your ability to practice as an athletic trainer with reasonable skill and safety? Please describe.</p>
Y	<p>3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider). Please describe.</p> <p>Y N 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.</p> <p>Y N 3b. If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.</p>
Y	<p>4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice athletic training with reasonable skill and safety? If you answer this question 'yes', please answer the following:</p> <p>Y N 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?</p> <p>Y N 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?</p> <p>Y N 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice as an athletic trainer with reasonable skill and safety?</p> <p>4d. Please explain. _____</p> <p>4e. Identify your treating physician. _____</p>
Y N	<p>5. Have you ever been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.</p>
Y N	<p>6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.</p>

Y N	7. Have you ever been denied a registration/certification/licensure or the privilege of taking an athletic trainer examination or has a conditioned registration/certificate/license ever been issued to you by any state board or other licensing authority? If so, give particulars.
Y N	8. Has your license/registration/certificate to practice athletic training or any other regulated profession in any state or country ever been voluntarily or involuntarily (i.e. by State Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a State Board or other licensing authority? If so, give particulars.
Y N	9. Have you ever been notified of any investigations by any state board, athletic trainer society, certifying authority or any health facility of any complaints against you relative to the practice as a athletic trainer, or have you been reprimanded or censured by any athletic trainer society or licensing board? If so, give particulars.
Y N	10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).
Y N	11. Have you ever been terminated for cause from employment as an athletic trainer? If so, give particulars.
Y N	12. Have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Y N	13. Have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed

RIGHTS OF SUBJECTS OF DATA

This information is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for registration. The information is classified as private while your application is pending or if your application is denied, and as public if your registration is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently registered by the Board.

AFFIDAVIT OF APPLICANT:

State of: _____

County of: _____

I, _____, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for registration in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my registration to practice as an athletic trainer in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this _____ day of _____, _____.

Signature of Applicant

Signature of Notary Public _____

My Commission Expires: _____

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

I certify that on the date set forth below, the individual named above did appear Personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this _____ day of _____, _____.

Signature of Notary Public _____

Expiration Date ____ / ____ / ____

Paste a recent photo, front-view
passport-type photo in this square

**NOTARY
SEAL**

Signature of Applicant



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ADDENDUM TO APPLICATION

1. BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name _____

Street Address _____

City _____ State _____ Zip _____

☐ I certify that I am not currently in workforce related to my practice, and I don't have a business address related to my practice.

2. MILITARY STATUS

Are you or your spouse returning from active military duty (discharged less than 6 months ago) or still in active military duty?

☐ No ☐ Yes. If discharged, please provide discharge date: _____

3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has been convicted of a felony or gross misdemeanor occurring on or after July 1, 2013 in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013 and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____

Conviction Type (Check one): ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

City: _____ State: _____ County: _____ Country: _____

Sentence: _____

☐ I certify that I have had no convictions on or after July, 1, 2013

Applicant name _____ Date _____



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ATHLETIC TRAINER Verification of Education

This form is for certification of athletic trainer education for general registration applicants and **must be must be completed and mailed by the facility directly to the Minnesota Board of Medical Practice.** Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to this Board.

Name _____ SS# _____
(Please Print)

Signature _____ Date _____

Date of Degree (if applicable) _____ Degree Received (if applicable) _____
(Month, Day, Year)

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

It is hereby certified that: (Name of Applicant) _____

Matriculated in: (Name of School) _____

A program located at: _____

This program was accredited by: (Name of accrediting Organization)

____ Commission on Accreditation of Athletic Training Education (CAATE)

____ Commission on Accreditation of Allied Health Education Programs (CAAHEP)

____ National Athletic Trainers' Association Professional Education Committee (NATA PEC)

And received a diploma conferring: (Degree) _____

On: (Month, Day, Year) _____

Any disciplinary action? Yes* _____ No _____

Any derogatory information on file? Yes* _____ No _____

President/Secretary/Dean/Registrar:

School

Print Name _____

Seal**

Signature _____

Date _____

Phone _____ Fax _____

*Please attach letter of explanation.

**If there is no school seal, attach letter of explanation on letterhead.



MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

ATHLETIC TRAINER Verification of BOC Certification

This form is for verification of Board of Certification (BOC) certification for general registration, equivalency, and reciprocity applicants. **The completed form must be mailed directly by BOC to the Minnesota Board of Medical Practice.** Any fees are the applicant's responsibility *. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Name _____ SS# _____
(Please Print)

Signature _____ Date _____

BOC COMPLETES THE FOLLOWING INFORMATION:

It is hereby certified that: (Name of Athletic Trainer) _____

Was issued certification number _____

And membership number _____

By the Board of Certification on: (Month, Day, Year) _____

Expiration date is: (Month, Day, Year) _____

Applicant is in good standing : (Yes/No) _____

School _____ Print name _____

Seal** _____ Signature _____

Title _____

Date _____

*BOC offers a credential verification service by mail for a \$25 fee per written verification for certified athletic trainers. Applicants should allow at least two to three weeks for processing and submit their request to the Board of Certification, Inc., 1415 Harney St, Ste 200, Omaha, NE 68102. (ph 877-262-3926). The direct link to order the written verification online is <http://www.bocatc.org/ats/certification-verification> Minnesota accepts electronic verification. Applicants must contact BOC directly to take the exam.

**If there is no seal, attach letter of explanation on letterhead.

7/2013



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ATHLETIC TRAINER Verification of Licensure/Registration

This form is for verification of all athletic trainer licenses or registrations from every board issuing any type of license including training, and temporary permit even if license is not current. **Each Board completing the form must mail directly to the Minnesota Board of Medical Practice.** Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, **directly to this Board.**

Print Name _____ SS# _____

Signature _____ Date _____

THE STATE BOARD COMPLETES THE FOLLOWING INFORMATION:

It is hereby certified that: (Name of Applicant) _____

Date of birth: (Month, Day, Year) _____

Was issued license/registration number: _____

By: (State) _____ On: (Month, Day, Year) _____

Expiration date is: (Month, Day, Year) _____

Issued on basis of: (Exam) _____

Disciplinary action ever initiated, pending, or invoked*: Yes _____ No _____

Ever voluntarily relinquished license*: Yes _____ No _____

School

Print Name _____

Seal**

Signature _____

Date _____

Phone _____ Fax _____

*If yes, please attach letter of explanation.

**If there is no seal, attach letter of explanation on letterhead.



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ATHLETIC TRAINER Recommendation Form

This form must be completed and mailed directly to the Minnesota Board of Medical Practice by two persons with whom applicant has worked with during the last five years.

At least one must be a physician or chiropractor. The other person may be a certified athletic trainer. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Applicant Name _____

Signature _____ Date _____

THE PERSON SERVING AS A REFERENCE COMPLETES THE FOLLOWING INFORMATION:

RECOMMENDATION FOR: (Print name of Applicant) _____

1. How long have you known the applicant? _____

2. What has been the nature of your relationship with the applicant? _____

3. How would you characterize the moral and professional conduct of the applicant? _____

4. Would you recommend the applicant for approval for registration for the practice of athletic training? _____

5. Place a checkmark by the word(s) which best describe this applicant.

A. Athletic Trainer Skills: _____Marginal* _____Fully Meets Standards

B. Any indication of chemical dependency? _____Yes* _____No

***Please attach letter of explanation**

Completed By:

Printed Name _____ Signed _____

Health Profession _____ License # _____ State _____

Date _____ Phone# _____ Fax _____ Email _____



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At least one must be a physician or chiropractor. The other person may be a certified athletic trainer. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Applicant Name _____

Signature _____ Date _____

THE PERSON SERVING AS A REFERENCE COMPLETES THE FOLLOWING INFORMATION:

RECOMMENDATION FOR: (Print name of Applicant) _____

1. How long have you known the applicant? _____

2. What has been the nature of your relationship with the applicant? _____

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A. Athletic Trainer Skills: _____Marginal* _____Fully Meets Standards

B. Any indication of chemical dependency? _____Yes* _____No

***Please attach letter of explanation**

Completed By:

Printed Name _____ Signed _____

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Treating Physician Statement

Applicant: Applicants who have a medical condition during the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their treating physician complete this form. A treating physician is the physician who diagnosed and provides or provided treatment for the condition and includes the current treating physician.

Treating Physician: Complete and mail this form directly to the Minnesota Board of Medical Practice. This form is also available on our website.

Applicant's Printed Name _____

Applicant's Date of Birth (Mo/Day/Yr) _____ Health Profession _____

I hereby authorize you, my treating physician, to disclose my medical records to the Minnesota Board of Medical Practice. I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing oral information or documents, records, or other information to the Board.

Signed _____ Date _____

Nature of medical condition including diagnosis and significant symptoms

Date first saw patient: _____ Date last saw patient: _____

Has the applicant been compliant with treatment? (If no, please explain)

☐ Yes ☐ No

What medications is the applicant taking for this condition?

If this medical condition was untreated, would it be likely to impair the applicant's ability to practice with reasonable skill and safety? (If yes, please explain) ☐ Yes ☐ No

Should the condition be monitored? (If yes, please explain) ☐ Yes ☐ No

Treating Physician (print name) _____

Signature _____ Date _____

Phone _____ Fax _____



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ATHLETIC TRAINER Temporary Permit Request

A temporary permit is available for athletic trainers who have applied for permanent registration and have complied with all requirements and wish to practice prior to the next Board meeting at which the application would be considered. Upon request, a temporary permit will be issued after eligibility for registration has been established and the credentialing and verification process has been completed. This process usually takes several weeks. The Board may, at its discretion, issue a temporary permit under the above conditions. A temporary permit is valid only until the next Board meeting at which a decision is made on the application.

Applicants requesting a temporary permit must complete this form and submit a non-refundable \$50 fee. This fee is in addition to the application and permanent registration fees. Please make checks payable to the Minnesota Board of Medical Practice.

Print Name _____

Temporary permit will be issued at the following proposed practice location:

(Hospital/Clinic)

(Street)

(City/State/Zip Code)

Professional telephone number: _____
(Including Area Code)

Anticipated date of commencing practice at proposed practice location: _____

Mailing address for temporary permit:



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ATHLETIC TRAINER Temporary Registration Request

A temporary registration is available for athletic trainers who have applied for permanent registration and have complied with all requirements and wish to practice prior to the next Board meeting at which the application would be considered. Exception: the Board may issue temporary registration to general registration applicants pending successful completion of the Board of Certification (BOC) certification examination formerly National Athletic Trainers' Association Board of Certification (NATABOC). Upon request, temporary registration will be issued after eligibility for registration has been established and the credentialing and verification process has been completed. This process usually takes several weeks. The Board may, at its discretion, issue temporary registration under the above conditions. Temporary registration is valid for one year.

Applicants requesting temporary registration must complete this form and submit a non-refundable \$100 fee. This fee is in addition to the application and permanent registration fees. Please make checks payable to the Minnesota Board of Medical Practice.

Print Name _____

Temporary registration will be used at the following proposed practice location:

(Hospital/Clinic)

(Street)

(City/State/Zip Code)

Primary physician's name: _____

Supervising Athletic Trainer's Name: _____ Reg# _____

Professional telephone number: _____

Anticipated date of commencing practice at proposed practice location: _____

Mailing address for temporary registration:

Athletic Trainers with temporary registration are limited to working under the direct supervision of an athletic trainer registered in Minnesota. Direct supervision means working under a registered athletic trainer who is present in the facility or readily available by telephone. A registered athletic trainer may supervise no more than four athletic trainers with temporary registration status.



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REGISTERED ATHLETIC TRAINER
PROTOCOL FORM

This protocol form is to be completed by the PRIMARY PHYSICIAN and must be typed or printed except where signatures are required. This protocol form must be updated and reviewed at the athletic trainer's renewal time and kept on file by the athletic trainer. It is recommended that the primary physician also retain a copy.

ATHLETIC TRAINER

Name _____

Street Address _____

City _____ State _____ Zip code _____

Registration # _____ Phone# _____

Date of Certification by National Athletic Trainers Association – Board of Certification (NATA-BOC) _____

PRIMARY PHYSICIAN

"Primary Physician means a licensed medical physician who serves as a medical consultant to an athletic trainer." (MN Statute 148.7802 Subd. 11) An athletic trainer may have more than one primary physician depending on employment sites. Make additional copies of this form as necessary. "The primary physician shall establish evaluation and treatment protocols to be used by the athletic trainer. The primary physician shall record the protocols on a form prescribed by the board." [MN Statute 148.7806(b)]

Name _____

Street Address _____

City _____ State _____ Zip code _____

License # _____ Phone# _____

ATHLETIC TRAINER SERVICES EVALUATION AND TREATMENT PROTOCOL

ATHLETIC TRAINERS PRIMARY EMPLOYMENT SITE WHERE PROVISIONS OF THIS PROTOCOL FORM APPLY. EACH PRIMARY EMPLOYMENT SITE MUST BE LISTED BELOW.

PRIMARY EMPLOYMENT SITE

“Primary Employment Site” means the institution, organization, corporation, or sports team where the athletic trainer is employed for the practice of athletic training.” (MN Statute 148.7806 Subd. 10)

1. **SITE 1** Facility or Employer Name _____
Street address _____
City _____ State _____ Zip code _____
2. **SITE 2** Facility or Employer Name _____
Street address _____
City _____ State _____ Zip code _____
3. **SITE 3** Facility or Employer Name _____
Street address _____
City _____ State _____ Zip code _____
4. **SITE 4** Facility or Employer Name _____
Street address _____
City _____ State _____ Zip code _____

LIMITED EVALUATION AND TREATMENT

“At the primary employment site, except in a corporate setting, an athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than 30 days or a period of time designated by the primary physician on the protocol form, from the date of the initial evaluation and treatment. Preventative care after resolution of the injury is not considered treatment. This paragraph does not apply to a person who is referred for treatment by a person licensed in this state to practice medicine as defined in section 147.081, to practice chiropractic as defined in section 148.01, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05 and whose license is in good standing.” [MN Statute 148.7806(c)]

“In a clinical, corporate and physical therapy setting, when the service provided is, or is represented as being, physical therapy, an athletic trainer may work only under the direct supervision of a physical therapist as defined in section 148.65.” [MN Statute 148.7806 (e)]

“Athlete” means a person participating in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.” (MN Statute 148.7802 Subd. 4)

“Athletic injury” means an injury sustained by a person as a result of the person’s participation in exercises, sports, games, or recreation requiring physical strength, agility, flexibility, range of motion, speed, or stamina.” (MN Statute 148.7802 Subd. 5)

ATHLETIC TRAINER SERVICES EVALUATION AND TREATMENT PROTOCOL

The PRIMARY PHYSICIAN shall affirmatively state by placing a "yes" in the blank in front of the services enumerated below, those evaluation, treatment and rehabilitative procedures that the athletic trainer may perform in managing athletic injuries. A "no" shall be put in the blank in front of the evaluation, treatment or rehabilitative procedures that the athletic trainer should not perform in the management of athletic injuries.

- _____ 1. At the primary employment site, except in a corporate setting, the athletic trainer may evaluate and treat an athlete for an athletic injury not previously diagnosed for not more than _____ days. (May not exceed 30 days.)
- _____ 2. Take a complete, detailed, and accurate history including history of past problems, history of present problem, mechanism of injury, anatomical location and pain characteristics.
3. Evaluate utilizing the following procedures:
 - _____ a. palpation for edema, deformity, pain, temperature difference, etc.
 - _____ b. general observation
 - _____ c. motion assessment
 - _____ d. muscle strength and endurance tests
 - _____ e. neurological assessment
 - _____ f. joint play assessment
 - _____ g. functional evaluation
 - _____ h. other (specify) _____
4. Treat utilizing the following procedures:
 - _____ a. give emergency care for athletic injuries
 - _____ b. provide appropriate therapeutic treatment for athletic injuries using the following therapeutic modalities
 - _____ (1) cryotherapy and thermotherapy
 - _____ (2) ultrasound
 - _____ (3) phonophoresis
 - _____ (4) electrical nerve stimulation
 - _____ (5) iontophoresis
 - _____ (6) diathermy (specify type: _____)
 - _____ (7) intermittent compression
 - _____ (8) traction
 - _____ (9) therapeutic massage
 - _____ (10) other (specify) _____
5. Rehabilitate utilizing the following procedures:
 - _____ a. progressive resistance exercise
 - _____ b. range of motion exercise
 - _____ c. trigger point therapy
 - _____ d. joint mobilization for range of motion only
 - _____ e. proprioceptive neuromuscular facilitation
 - _____ f. functional exercise
 - _____ g. cardiovascular exercise
 - _____ h. other (specify) _____
6. Other approved procedures:
 - a. _____
 - b. _____
 - c. _____
 - d. _____

ATHLETIC TRAINER SERVICES EVALUATION AND TREATMENT PROTOCOL

SCOPE OF PRACTICE

"An athletic trainer shall:

(1) prevent, recognize, and evaluate athletic injuries; (2) give emergency care and first aid; (3) manage and treat athletic injuries; and (4) rehabilitate and physically recondition athletic injuries. The athletic trainer may use modalities such as cold, heat, light, sound, electricity, exercise, and mechanical devices for treatment and rehabilitation of athletic injuries to athletes in the primary employment site." [MN Statute 148.7806 (a)]

"An athletic trainer may:

(1) Organize and administer an athletic training program including, but not limited to, educating and counseling athletes;

(2) Monitor the signs, symptoms, general behavior, and general physical response of an athlete to treatment and rehabilitation including, but not limited to, whether the signs, symptoms, reactions, behavior or general response show abnormal characteristics; and

(3) Make suggestions to the primary physician or other treating provider for a modification in the treatment and rehabilitation of an injured athlete based on the indicators in clause (2) [MN Statute 148.7806 (d)]

LIMITATIONS ON PRACTICE

"If an athletic trainer determines that the patient's medical condition is beyond the scope of practice of that athletic trainer, the athletic trainer must refer the patient to a person licensed in the state to practice medicine as defined in section 147.081, to practice podiatry as defined in section 153.01, or to practice dentistry as defined in section 150A.05, and whose license is in good standing and in accordance with established evaluation and treatment protocols. An athletic trainer shall modify or terminate treatment of a patient that is not beneficial to the patient, or that is not tolerated by the patient." (MN Statute 148.7807)

PRIMARY PHYSICIAN

I have carefully read, understand, and agree to the foregoing Registered Athletic Trainer Protocol Form and certify that all information I have provided is accurate and correct. I understand that I am responsible for selecting appropriate functions to be performed by the athletic trainer under this protocol.

Signature _____ Date _____ Phone # _____

Note: Be sure to approve only those procedures you know the athletic trainer to be proficient at. This protocol form may be updated at your discretion.

ATHLETIC TRAINER

I have carefully read, understand, and agree to the foregoing Registered Athletic Trainer Protocol Form and certify that all information I have provided is accurate and correct. I understand that I am responsible and capable for functions delegated, for selecting appropriate functions to be performed under this protocol and for performing them properly.

Signature _____ Date _____ Phone # _____

10/99